

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 29 1954

State File No. 3523
Registrar's No. 3523

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Kentucky b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Mayfield	d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens		e. STREET ADDRESS (If rural, give location) 852 S. 2nd	
3. NAME OF DECEASED (Type or Print) ROBERT EUGENE ALEXANDER		4. DATE OF DEATH (Month) (Day) (Year) 4-18-54	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 1-20-54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or foreign country) Mayfield, Ky.
12a. FATHER'S NAME Robert Alexander		13b. MOTHER'S MAIDEN NAME Frances Pullack	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME S. Salantow ADDRESS 500 Washington
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) lyonic stenosis INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 4-17-54		19b. MAJOR FINDINGS OF OPERATION Hypertrophied pyloric sphincter	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 756.0		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-15 , 19 54 , to 4-18 , 19 54 , that I last saw the deceased alive on 4-18 , 19 54 , and that death occurred at 6:50 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) A. J. Wohltman, M.D.		23b. ADDRESS Childrens Hospital	
23c. DATE SIGNED 4-18-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-18-54	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (city, town, or county) (State) Mayfield, Ky.	
DATE REC'D BY LOCAL REG. APR 19 1954		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Edmond H. Remelero*

Licensed Embalmer No. *428*

P. O. Address *St. Louis,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.